

SCREENING/NEEDS ASSESSMENT
(T1023-FP)

Participant's Name: _____

Date of Service: _____ **Medicaid Number:** _____

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

(Provider of Service)

Licensed/Certified Signature: _____ **Date:** _____